

that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan has the meaning given the term in 45 CFR 146.113(a)(1)(ix).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.

Significant break in coverage has the meaning given the term in 45 CFR 146.113(b)(2)(iii).

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Small group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

Special enrollment means enrollment in a group health plan or group health insurance coverage under the rights described in 45 CFR 146.117.

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool has the meaning given the term in 45 CFR §146.113(a)(1)(vii).

Waiting period has the meaning given the term in 45 CFR 146.111(a)(3)(iii).

[69 FR 78781, Dec. 30, 2004]

Subpart B [Reserved]

PART 145 [RESERVED]

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

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§ 146.101

AUTHORITY: Secs. 2705, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg-5, 300gg-91, and 300gg-92).

SOURCE: 62 FR 16958, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 146.101 Basis and scope.

(a) *Statutory basis.* This part implements sections 2701 through 2723 of the PHS Act. Its purpose is to improve access to group health insurance coverage, to guarantee the renewability of all coverage in the group market, and to provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations, respectively.

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this part.

(1) *Subpart B.* Subpart B of this part sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(i) Limitations on a preexisting condition exclusion period.

(ii) Certificates and disclosure of previous coverage.

(iii) Methods of counting creditable coverage.

(iv) Special enrollment periods.

(v) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

(vi) Prohibiting discrimination against participants and beneficiaries based on a health factor.

(2) *Subpart C.* Subpart C of this part sets forth the requirements that apply to plans and issuers with respect to coverage for hospital stays in connection with childbirth. It also sets forth the regulations governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in connection with a group health plan.

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(3) *Subpart D.* Subpart D of this part sets forth exceptions to the requirements of Subpart B for certain plans and certain types of benefits.

(4) *Subpart E.* Subpart E of this part implements sections 2711 through 2713 of the PHS Act, which set forth requirements that apply only to health insurance issuers offering health insurance coverage in connection with a group health plan.

(5) *Subpart F.* Subpart F of this part addresses the treatment of non-Federal governmental plans, and sets forth enforcement procedures.

[62 FR 16958, Apr. 8, 1997, as amended at 63 FR 57559, Oct. 27, 1998; 71 FR 75046, Dec. 13, 2006]

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

§ 146.111 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion—(1) Defined—(i)* A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(ii) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples: